MDR Tracking Number: M5-04-3016-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution-General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on May 13, 2004.

The Requestor submitted an up-dated Table of Disputed Services on August 6, 2004.

The IRO reviewed office visits (99213), physical performance test (97750), functional capacity evaluation (97750-FCE), therapeutic exercises (97110), ROM (95851), manual therapy (97140), paraffin bath (97018), electrical stimulation (G0283), physician review of computer based analysis (96004), ultrasound (97035) rendered from 08/12/03 through 12/22/03 that was denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

The office visit (99213) for dates of service 10/01/03, 10/07/03, 10/22/03, 11/03/03, and 11/13/03; therapeutic exercises (97110); manual therapy (97140); physical performance testing (97750); ROM measurements (95851); paraffin bath (97018); and electrical stimulation (G0283) **were** found to be medically necessary. The functional capacity evaluation for date of service 09/17/03 and the office visits for dates of service 10/08/03, 10/14/03, 10/16/03, 10/17/03, 10/20/03, 10/24/03, 10/27/03, 10/28/03, 10/29/03, 11/05/03, 11/07/03, 11/10/03, and 11/11/03 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for service/treatments denied for medical necessity.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On July 1, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

- CPT Code 97124 for date of service 08/04/03. Neither the requestor nor the respondent submitted EOB's. These dates of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, reimbursement is recommended in the amount of $28.44 ($22.75 x 125%).

- CPT Code 97140 for date of service 08/04/03. Neither the requestor nor the respondent submitted an EOB. This date of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, reimbursement is recommended in the amount of $34.05 ($27.24 x 125%).

- CPT Code 99213 for dates of service 08/04/03 and 10/28/03. Neither the requestor nor the respondent submitted EOB's. These dates of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, reimbursement is recommended in the amount of $132.38 ($52.95x 125% = $66.19 x 2).

- CPT Code 97546-WH (28 hours) for dates of service 09/02/03 through 09/15/03 denied as "V". Requestor has submitted preauthorization approval. Per 133.301(a) the carrier has incorrectly denied the services/treatment. Non-CARF accredited amount is 80% of $64.00 per hour, which is $51.20 per hour. Reimbursement in the amount of $1,401.60 ($51.20 x 28 hrs = $1,433.60 - $32.00, amount paid by carrier) is recommended.

- CPT Code 97545-WH (18 hours) for dates of service 09/03/03 through 09/15/03 denied as "V". Requestor has submitted preauthorization approval. Per 133.301(a) the carrier has incorrectly denied the services/treatment. Non-CARF accredited amount is 80% of $64.00 per hour, which is $51.20 per hour. Reimbursement in the amount of $921.60 is recommended.

- CPT Code 99080-73 for date of service 10/16/03. Neither the requestor nor the respondent submitted an EOB. The Work Status Report (TWCC-73) is a required report. Per Rule 129.5 and 133.106(f)(1) reimbursement in the amount of $15.00 is recommended.

- CPT Code 97018 for date of service 10/28/03. Neither the requestor nor the respondent submitted an EOB. This date of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, reimbursement is recommended in the amount of $6.88. MAR for this code under the Medicare Fee Schedule times 125% is $8.60; however, requestor has requested the Medicare Fee Schedule amount only.

- CPT Code 97110 for date of service 10/28/03. Neither the requestor nor the respondent submitted an EOB. This date of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. Reimbursement not recommended.

- CPT Code G0283 for date of service 10/28/03. Neither the requestor nor the respondent submitted an EOB. This date of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, reimbursement is recommended in the amount of $16.63 ($13.30 x 125%).

- CPT Code 95851 for date of service 01/30/04. Neither the requestor nor the respondent submitted an EOB. This date of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, reimbursement is recommended in the amount of $26.40.

- CPT Code 95852 for date of service 01/30/04. Neither the requestor nor the respondent submitted an EOB. This date of service will be reviewed in accordance with Rule 134.202 effective 8-1-03. Since the carrier did not provide a valid basis for the denial of this service, reimbursement is recommended in the amount of $18.58.

This Decision is hereby issued this __9th_____ day __October_____ 2004.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

MF/mf

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 08/04/03 through 01/30/04 in this dispute.

This Order is hereby issued this _9th ____ day of _October_____ 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/mf
Enclosure: IRO Decision

NOTICE OF INDEPENDENT REVIEW DECISION – AMENDED DECISION

Date: September 17, 2004

RE:
MDR Tracking #: M5-04-3016-01
IRO Certificate #: 5242

_____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to _____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

_____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents

utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Submitted by Requester:

- Assorted medical dispute resolution request forms.
- Numerous EOB's reflecting dates of service from 11/24/03 through 12/22/03.

Submitted by Respondent:

- Approximately 114 pages, treating doctor clinical SOAP notes and examination report by _____ and _____

Clinical History

The claimant allegedly received bilateral wrist/hand injury (diagnosed as carpal tunnel syndrome) said to be resultant of repetitive work duties, reportedly while working for her employer, on or about ___.

Numerous evaluations, assessments and peer reviews, concur to the claimant's chronic pain and radiculopathy, as associated with the said work related incidents (s).

Requested Service(s)

Office visits (99213), FCE (97750), functional capacity evaluation, therapeutic exercises (97110), range of motion measurements (95851), manual therapy technique (97140), paraffin bath (97018), electric stim unattended (G0283), physician review of computer based analysis (96004), ultrasound (97035). Do not review DOS 9/2/03, 9/15/03, 10/28/03 or 99080-73 (required report).

Decision

I disagree with the insurance company and find that E/M code 99213 (office visit) 10/01/03, 10/07/03, 10/22/03, 11/03/03, 11/13/03; 97110 (therapeutic exercise); 97140 (manual therapy technique); 97750 (FCE); 95851 (ROM measurements); 97018 (paraffin bath); G0283 (Electric stim unattended) were medically necessary for dates of service 10/01/03 through 11/13/03.

I agree with the insurance carrier and find that E/M code 97750-FC on date of service 9/17/03 and code 99213-(office visits) on 10/08/03, 10/14/03, 10/16/03,10/17/03, 10/20/03,10/24/03, 10/27/03, 10/28/03, 10/29/03, 11/15/03, 11/07/03, 11/10/03 and 11/11/03, were not medically necessary.

E/M code 96004 (physician review of computed based analysis; 97035 (ultrasound) were not part of this review in connection with date of service 9/12/03 and 10/01/03 thru 11/17/03.

Rationale/Basis for Decision

According to the available documentation received from the treating doctor, it appears the request for reconsideration of dates of service on 8/12/03 and 11/17/03-12/22/03 has been withdrawn and is not in dispute and is, therefore, not part of this decision review.

The remaining dates of service: 10/01/03 – 11/13/03 to include 9/17/03, are the focus of this decision.

It does appear the claimant had received left carpal tunnel release on 9/25/03, for failure of conservative care to alleviate related symptomatology. With this in mind, post surgical rehab would still be an integral part of reasonable and necessary treatment expected for this type of surgical procedure and supported by established guidelines.

It also appears the treating doctor followed treatment parameter guidelines while administering this post care. Support is demonstrative by objective criteria of continued improvement in all categories in regards to the left side, based on these reports. Whether or not the right side was responding, does not disqualify the need for this post surgical rehab, which is considered medically necessary. The rehab was not excessive in frequency or duration for the post rehab (6 weeks), whereas in most cases, the time frame is 8 to 12 weeks.

Concerning code (97750) Functional Capacity Evaluation: This would be considered necessary if in fact, the claimant was in a return to work consideration status or to gauge if improvement is progressing during the program, to decide if continuation is beneficial. Neither of these points appeared to be satisfied with the administering of this FCE. The necessity for its use does not appear to fulfill any useful purpose, nor was it used to make medical decisions. It was already apparent the claimant was not progressing and the decision to proceed with surgical intervention appeared to already be decided, whether or not an FCE was performed. The claimant would be a baseline starting point and the information provided from the pre-surgical FCE would be of no value.

Concerning Code 99213 – (office visits) Throughout the dates of service timeframe, 10/01/03-11/13/03; since we are dealing with post surgical rehab, there is no reason that the monitoring process should involve an office visit frequency of more than 2 times per month. Unless extenuating circumstances or a definite change in the claimants condition was apparent the need for a more frequent schedule is not established or for that matter, necessary. The use of chiropractic manipulation would not be supported post-release surgery and its use on the right apparently, did not demonstrate any progressive gain and would not be reasonable or necessary.

Concerning code 95851 (ROM): This was beneficial in establishing rate of progressive recovery, and appears that it helped in keeping the rehab therapy timeframe at a level of moderation, where a lot of times the treatment usually lingers, 8 to 12 weeks, whether it is needed or not.

Concerning code 97018 (paraffin bath) and G0283 (EMS, unattended): used in replacement of moist heat therapy and for pain control at various times throughout the rehab phase is reasonable did not appear excessive or non-beneficial.